Low Income Health Program (LIHP) Application

GENERAL INFORMATION

1. Applicant Name: _____

   Address: _____
   City: _____
   County: _____
   Zip: _____

2. Name of authorized official: _____

3. Name of Contact: _____

   Phone: _____ Fax: _____
   Email: _____

4. Low Income Health Program (LIHP) Name:
   _____

5. Indicate the applicant type:

   ☐ County ☐ City and County ☐ Health Authority

   ☐ Consortium of counties serving a region consisting of more than one county. Identify each participating county member of the consortium.
   _____

6. Check the appropriate box for the program(s) under the LIHP to be implemented and the proposed date of program implementation. In determining this date, consider the estimated timeframes for application approval and authorization by DHCS. This implementation date must be approved before an authorized applicant may implement the program(s).

   ☐ MCE Proposed implementation date. _____

   ☐ HCCI Proposed implementation date. _____

   For those applicants that are not proposing to implement a HCCI under the LIHP, check the appropriate box below.

   ☐ Will not implement a HCCI. _____

   ☐ Not planning to implement a HCCI at this time.

Note that a HCCI program can not be implemented if a MCE program is not implemented.

Refer to "Program Requirements".*

***Note that all the sections referenced in the application are in the Program Requirements and Application Process – Low Income Health Program document.**

PROVIDER NETWORK

7. Will the applicant's delivery system(s) be an open or closed network?

   ☐ No ☐ Yes

8. Will the applicant's delivery system(s) include managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care cast management systems (PCCMs)?

   ☐ No ☐ Yes

   If yes, check the box for those organizations that applicant anticipates including in the delivery system.

   ☐ MCOs ☐ HIOs ☐ PIHPs

   ☐ PAHPs ☐ PCCMs

9. Will the applicant's delivery system(s) for mental health services be separate (carved out) from that of the applicant's network? If yes, applicant must complete Attachment 7.

   ☐ No ☐ Yes

Refer to "Provider Network Delivery System".

ELIGIBILITY AND ENROLLMENT

10. Indicate the proposed upper income limit for the applicable LIHP.

    - MCE upper income limit at or below _____ percent of the FPL.
    - HCCI upper income limit above 133 percent through _____ percent of the FPL.

Refer to "Eligibility and Enrollment Requirements – Income Standards."

11. Indicate the non-binding estimates of enrollees by program year (PY). Only applicants with existing HCCI programs should complete the columns for existing enrollees:

Program Year	MCE Population		HCCI Population	
	Existing (Enrolled in the HCCI on 11/1/10)	New (Enrolled 11/2/10 or after)	Existing (Enrolled in the HCCI on 11/1/10)	New (Enrolled 11/2/10 or after)
PY 1				
PY 2				
PY 3				
PY 4				

Refer to "Definitions."

12. Indicate below the projected expenditure level which will trigger an enrollment cap.

HCCI expenditure level _____

MCE expenditure level _____

Refer to "Eligibility and Enrollment Requirements – Income Standards and MCE Enrollment Requirements".

13. Check the appropriate box below and fill in for the proposed retroactive period where appropriate.

☐ MCE retroactive eligibility period will be ____ months. (1-3 mos.)

☐ MCE retroactive eligibility period will not be allowed.

☐ HCCI retroactive eligibility period will be ____ months. (1-3 mos.)

☐ HCCI retroactive eligibility period will not be allowed.

Refer to "Eligibility and Enrollment Requirements."

EXPENDITURE AND REIMBURSEMENT MECHANISM

14. Place a check mark in the appropriate column to indicate the anticipated reimbursement mechanism for each program year. The mechanisms can change from year to year but both methods (Fee-for-Service or actuarially sound capitated rate) can not be combined within the program.

MCE Program

Program Year	Fee-for-Service Based on CPEs	Actuarially Sound Capitated Rate	
		Non-federal Share Provided through IGTs	Non-federal Share Provided through CPEs paid to 3rd party.
PY 1			
PY 2			
PY 3			
PY 4			

HCCI Program

Program Year	Fee-for-Service Based on CPEs	Actuarially Sound Capitated Rate	
		Non-federal Share Provided through IGTs	Non-federal Share Provided through CPEs paid to 3rd party.
PY 1			
PY 2			
PY 3			
PY 4			

Refer to "LIHP Funding Amounts and Requirements – Reimbursement Mechanisms."

15. Indicate in the appropriate column by program year the amount of anticipated total funds expenditures (TFEs) for each proposed program(s)

Program Year	MCE TFEs	HCCI TFEs	Total TFEs
PY 1			
PY 2			
PY 3			
PY 4			

Refer to "Definitions".

16. HCCI Allocation Request: Indicate in the table below the requested allocation amount for federal funds. Only applicants with existing HCCI enrollees should complete the column for Existing HCCI Enrollee.

Refer to "LIHP Funding Amounts and Requirements - Allocation Process and Requirements."

Program Year	New Enrollee HCCI Allocation	Existing HCCI Enrollee Allocation	Total
PY 1			
PY 2			
PY 3			
PY 4			

17. Complete attachments 1 through 8 as applicable. Indicate on the attachment if it is not applicable.

Acknowledgements:

The applicant:

- Will comply with program requirements, standards, and performance measurements pursuant to Welfare & Institutions. Code § 15909 *et seq.* and other applicable requirements, as set forth in the Special Terms and Conditions of the Demonstration.

- Asserts that this application was developed in collaboration and partnership with other county departments, including the county Departments of Mental Health, Social Services, and Health Services.

- Voluntarily agrees to provide the non-federal share of LIHP project expenditures in an amount to be determined by the applicant annually.

I hereby certify that I am authorized to submit this application on behalf of the applicant. On behalf of _____,

_____

Signature

_____

Title

_____

Date

If unable to obtain approval from the County Board of Supervisors or other governing boards as appropriate, prior to submission of the application, indicate below the estimated date when the approval will be provided to DHCS.

ATTACHMENT 1
INCOME RULES FOR MCE ELIGIBILITY DETERMINATIONS

Explain specific income rules that will be used for making eligibility determinations for the MCE program. Include income that will be exempted, deducted, disregarded when determining MCE income eligibility.

Refer to "Eligibility and Enrollment Requirements."

ATTACHMENT 2
INCOME RULES FOR HCCI ELIGIBILITY DETERMINATIONS

Explain specific income rules that will be used for making eligibility determinations for the HCCI program. Include income that will be exempted, deducted, disregarded when determining HCCI income eligibility.

Refer to "Eligibility and Enrollment Requirements."

☐ Check here if the same income rules used for MCE are used for HCCI.

ATTACHMENT 3
Add-on Health Care and Mental Health Services for MCE and HCCI.

Indicate in the appropriate tables below any add-on services allowable under Section 1905(a) of the Social Security Act that the applicant proposes to provide in addition to the minimum core benefits, the mental health minimum benefits package for the applicable program, and the proposed date when the services will be implemented in the proposed program(s). Also indicate add-on substance abuse services separately.
Refer to "Program Requirements - Health Care and Mental Health Services.".

Add-on Health Care Services	Proposed Implementation Date	MCE	HCCI

Add-on Mental Health Services	Proposed Implementation Date	MCE	HCCI

Add-on Substance Abuse Services	Proposed Implementation Date	MCE	HCCI

ATTACHMENT 4
LIHP COST-SHARING

Specify any cost sharing that will be imposed by service. If cost sharing is imposed, also explain how the aggregate cost will be limited to five percent per family.

Refer "Program Requirements – Cost Sharing Requirements."

MCE:

HCCI:

ATTACHMENT 5
LIHP NETWORK ADEQUACY

Complete the table below with the number of primary, specialty, and emergency care providers by type to describe your proposed provider network for the LIHP. Add other types of providers to the table below as needed. Approved applicants will be asked to provide additional information to determine network adequacy and access at a later date before authorized to implement the LIHP.

Refer to "Provider Network Delivery System."

Provider Type	Number of Primary Care Providers	Number of Specialty Care Providers	Number of Emergency Care Providers
Physician			
Non-Physician Medical Practitioner			
Pharmacist			
Clinic			
FQHC			
Hospital			

Provide the anticipated ratio of primary care physicians to MCE enrollees_____

Provide the anticipated ratio of primary care physicians to HCCI enrollees_____

Alternative Access Standards

Describe any geographic areas served by the LIHP that are eligible for alternative access standards. Attach a map to the application to illustrate these geographic areas.

ATTACHMENT 6
LIHP FUNDING AND CAPITATION RATE DEVELOPMENT

List the anticipated source(s) of non-federal funds for the LIHP and include funding from governmental entities other than the applicant.

Refer to "LIHP Funding Amounts and Requirements – Reimbursement Mechanisms."

Provide the status of the development of capitated rates for the LIHP, including the following: who is developing the rates and the projected date the capitation rate information will be submitted to DHCS.

ATTACHMENT 7
MENTAL HEALTH SERVICES DELIVERY SYSTEM AND REIMBURSEMENT MECHANISM

If the applicant's delivery system(s) for mental health services is separate (carved out) from that of the applicant's provider network, please describe the delivery system and the reimbursement mechanism for these services. If unable to provide this information with the application, indicate the date that it will be submitted to DHCS. **Refer to "Provider Network Delivery System."**

ATTACHMENT 8
LIHP ELIGIBILITY AND ENROLLMENT SYSTEM

Fully describe the manner in which the LIHP will process, screen and determine eligibility; and enroll eligible applicants into the LIHP. If appropriate, include in the description the use of any electronic and/or web-based system(s), any eligibility and/or enrollment software product(s) used for processing applications, screening, eligibility determinations, and case management and how such systems/products ensure consistent eligibility determinations. Also include, if warranted, the roles and responsibilities of the county department of health services and social services in eligibility determinations for LIHP enrollees. If unable to provide this information with the application, indicate the date that it will be submitted to DHCS.

Refer to "Eligibility and Enrollment Requirements."